Session 11

Doug Coslett: Is an employer allowed to disclose substance treatment information (including fact of in treatment) to others ?

- Presenter Dr. Landess responded: Hi Doug- Generally no- not without the employee's consent. There are other exceptions such as court orders. Also, another scenario may be where the employee is under monitoring by the state medical or other licensing board, and the employer is sharing certain information with that entity. But generally speaking disclosing this info without consent may be a legal problem including under the ADA, HIPAA, others.

Stephen Gibert: Self determination should trump (sorry!) beneficence unless the patient is incompetent.

Megan Miller, MD: Is there a simple tool that can be used to determine decisional capacity?

- Dr. Holoyda: There are some standardized tools that have been developed, but each case should be assessed individually due to different pathology and the interplay between different psychiatric disorders and capacity.
- Dr. Landess: Megan, for decisional capacity I would also read Appelbaum 2007 NEJM article which has a nice synopsis/chart.

Dr. Luther: Is an intervention, where a person agrees to treatment only because they were coerced by family members (I'll divorce you if you don't go to treatment) legal?

- Dr. Holoyda: Yes, there is nothing illegal about a family member threatening to leave a spouse if he/she does not receive treatment and the individual subsequently seeking treatment.
- Dr. Luther: What if the person's primary MD was present and stated they would no longer care for the patient if they didn't go to treatmemt?
- Dr. Holoyda: That would certainly be more coercive and the PCP should make arrangements to transfer care to another provider willing to see that patient.

Maria Robles: Does 42 CFR apply to treating SUD in primary care using MOUD?

- Adam Lake: especially if you use an EMR, are there guidelines around this?
- Dr. Holoyda: It could apply to treating SUDs in primary care, if the clinic meets the criteria as a covered entity (which cast a wide net).
- Dr. Holoyda: It is a bit more than you need to know from this lecture, but this is a link to SAMHSA's information on exchanging Part 2-protected information: https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

Arthur Weissman: does this mean that a freestanding methadone clinic is not a covered entity

- Dr. Holoyda: It likely would be a covered entity, since it would presumably be registered with the DEA under the Controlled Substances Act.
- Arthur Weissman: but the definition that the speaker gave specified that 42 CFR is within a general medical setting, and implied ONLY within a general medical setting. I have read 42CFR and it doesn't say this. Should be clarified.
- Dr. Holoyda: Apologies for the confusion. 42 CFR Part 2 applies to freestanding organizations, as well, not those solely within a general medical unit.

ST Weiss: So what would be an example of a tx program that is NOT covered by 42CFR2? A cash-only practice for wealthy patients? It seems like pretty much every other scenario would be included.

- William Walsh, MD: I think it would not technically fall under 42cfr2, but following it would be advised. Explaining why you didn't would be fun in court (malpractice)
- Dr. Holoyda: Being cash-only is not exclusionary if you are providing treatment for substance use disorders and prescribing relevant medications (like buprenorphine) under a DEA license.
- ST Weiss: Ok, so basically there are no exceptions if you are providing OAT since you'd still need to register with the DEA.
- Dr. Holoyda: Correct.
- ST Weiss: Thank you.

Leslie Hayes: Is gabapentin Schedule V on a national basis? I thought it varied state by state.

- Adam Lake: pregabalin is schedule 5 in PA, but gabapentin isn't in PA - at least to my knowledge.
- Dr. Landess: Gabapentin is scheduled and reportable to PDMP state by state

David Roll: Recently one of my primary care buprenorphine patients continued polysubstance use and declined referral to higher level of care throughout her pregnancy. Some of her providers advocated for involuntary commitment, citing risk of harm to the fetus. How should I think about my legal and ethical obligations in this situation?

- Leslie Hayes: I would be very hesitant to do this. Just getting prenatal care is going to improve her outcome, and she will probably not return to you for this if she is committed involuntarily. In addition, depending on where you live, they may stop her buprenorphine in an inpatient setting, which will not be beneficial.
- Dr. Landess: There are only three states that allow civil commitment of woman on this basis and it is controversial. We will discuss the criteria for civil commitment in a future slide as well. I agree that this situation is fraught with ethical and legal concerns.
- Sree Atluru: Wisconsin is one of the states that allow forcible civil commitment and forcible treatment of people pregnant people with SUD via WI State Statute 292. It deters pregnant people from seeking care.
- Dr. Landess: That is correct re: wisconsin. There was a recent appellate case involving this issue but by the time it reached the higher court the woman was no longer pregnant so they deemed the case moot.

Avani Sheth: Can you please review approach to the first scenario at the beginning of the Ethics presentation during the faculty panel time?

- Dr. Holoyda: Yes. Approaching such a complex situation involves assessing the ethical principles at stake for both the individual patient and those put at risk by her substance use, then working with the patient to reduce the risk she poses.

Sadie Knott: Will you please comment further on the Complex Ethical Scenario (slide #10)

- Dr Luther: My treatment center commonly encounters situations like this. Some states, like ours, have PHP programs that can provide monitoring without notifying the board. Some states don't have PHP's and the boards can be very vindictive. Very difficult situation!

- Dr. Holoyda: This is a good point. In such a case, the provider may consider encouraging the patient to enter a physician health program through the state, though there are serious risks to the patient's future ability to practice if he or she does so.
- Dr. Luther: Agree.

Leslie Hayes: The studies have shown that the more punitive policies in states lead to increased rates of neonatal abstinence syndrome.

Lisa Hadley: Can you comment on any states treating MAT as substance use during pregnancy

- Dr. Landess: Hi Lisa, Can you clarify your question?

Michael Fiori: Cannabis use in pregnancy?

- Dr. Landess: Can you please clarify your question?

Dr. Robert S. Bernstein: In CA, a barrier to availability / access to MAT in jails and prisons is the failure of Title 15 and agencies (BSCC) to update Minimum STandards of Care and Treatment, and the failures of contracted providers (WellPath, others)

Greg Gramelspacher: what are the legal implications of prescribing methadone in a primary care setting who has BOTH chronic pain AND OUD? Assume that the chronic pain has been unresponsive to all non-opioid treatments/interventions.

- Juliette: Great question. I'd like to know too since pts getting methadone from OTPs present to my clinic for tx of their chronic pain.
- Leslie Hayes: I have known physicians facing federal charges in this situation. It is not worth the risk.
- Juliette: in the OUD session, we were told we can treat chronic pain with methadone (I do NOT do it because of the potential risks/AE's with methadone in older adults).
- Greg Gramelspacher: methadone is a VERY effective pain medication (based on a long palliative care practice) and even elderly patients can be effectively treated with low dose methadone (5 mg 2-3 times per day).
- Greg Gramelspacher: “zoomed out" is RIGHT
- Greg Gramelspacher: considering the prevalence of dual diagnosis, shouldn't all psychiatrists have MAJOR education in SUDs? And conversely, all physicians treating SUDs should know ALOT about the major psychiatric conditions and preferably have ready referral to Psychiatry. The best model, as you suggest, is having both co-located.

Juliette: Are there any legal risks of petitioning and cert'ing a patient without a dx'd SMI, but pt states SI/HI?

- Dr. Holoyda: I have not seen a state hold that requires a formal psychiatric diagnosis prior to placing a petition for civil commitment.
- Dr. Landess: No. As long as there is an imminent risk and some concern for a mental health problem (no formal diagnosis needed) that is enough for an emergency detention. If the person stabilizes and/or has no mental illness after detention, the judge will likely not find them appropriate for civil commitment.

- Jamie Redwing: have there been any lawsuits against MDs who RX syringes?

Leslie Hayes: I have seen a lot written recently about the harm of calling for a welfare check or a 72-hour hold in cases where a patient is making suicidal statements. (Harm including significant disruption to people's lives and future lack of trust in the medical system.) Is there any study on the long-term outcomes of these?

- Dr. Holoyda: I am not aware of long-term outcome studies on the effects of a 72-hour hold. Generally, preventing a patient from committing suicide outweighs the potential risks associated with being placed on a hold.
- Leslie Hayes: What the disability advocates I have read stated that they have been committed for suicidal thoughts when they really had no intent, and that they felt far less likely to reach out in the future and that depression was much worse afterwards. I am curious if their experience has been seen in studies or not.

Ayesha: what are those 37 states that allow civil commitment on the basis of substance use disorder

- Dr. Landess: treatmentadvocacycenter.org is a good resource to find the law in your state

John Vigil: What about a physician who voluntarily presents with OUD and wants buprenorphine, but the Medical Board or the Employer/Hospital does not allow?

John Vigil: What about reporting a HCP, such as a nurse or Mid Level that is actively using but seeking treatment, but you know is still going to work and using?